

The Law of Professional Negligence

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Practice Management to Avoid a Lawsuit –
The Law of Negligence and Professional Liability

By James F. Wilson, DVM, JD

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CLIENT COMPLAINTS & THE LAW OF NEGLIGENCE

PRACTICE MANAGEMENT TO AVOID A LAWSUIT

By James F. Wilson, DVM, JD

- I. **THE ORIGIN OF CLIENT COMPLAINTS** and, all too often, the resultant refusal to pay for services rendered.

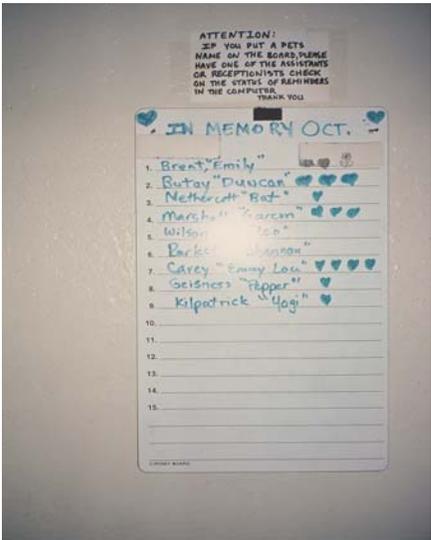
Chapter 5 in the *Law and Ethics of the Veterinary Profession* book is a recommended resource for understanding the origins of client complaints and how to handle them. (For the table of contents go to www.pvmc.net and click on publications; call (215) 321-9488 for pricing or to order. Readers will discover that many of the key origins discussed many years ago lie in the same common, often subtle comments that are uttered unwittingly or simply missed by veterinarians lacking strong communication skills today. Key causes of complaints include the following ones.

1. **Breakdowns in communications** about medical care and fees. (Doctors think all many clients care about is inexpensive care. Many clients think their veterinary clinicians care only about money.) *L & E* book p. 111–117. See also *Handbook of Veterinary Communication Skills* by Moffett and Clay, www.Wiley-Blackwell.com. \$49.95 – less with bulk purchases by students. These communication breakdowns include the following:
 - a. Client misconceptions and failure to understand that medicine is an inexact science, thus, it is difficult to predict fees for unexpected complications.
 - b. **Veterinarians’ failure to understand that without the provision of a *medical care plan*** - historically referred to as an *estimate*, it is difficult to create an enforceable contract. As costs for veterinary care have risen exponentially and veterinarians have wish to look less like the auto mechanics and contractors, who provide *estimates* for repairs of inanimate property, the term *medical care plan* has taken hold. This term includes a) developing a diagnostic plan, b) outlining a possible treatment plan and c) linking fees to the combination of these two. Key issues and great state board examples that occur when clients fail to request and/or their doctors’ fail to provide estimated costs can be found in Chapter 5 of the *L & E* book *L & E* book p. 114–116.
 - c. Veterinarians’ failure to understand that exceeding the estimated costs without client acceptance = a breach of contract. Not only does this make it hard to collect fees owed, it can lead to state board complaints and serious public relations difficulties.
2. The **failure to compromise on fees** when cases fail to recover as expected can lead to serious public relations problems, state board complaints and lawsuits. Methods to thwart the assumption that compromises = an admission of wrongdoing and/or negligence are found in *L & E* p. 116-117.
3. The failure to **provide a satisfactory quantity and quality of veterinary care**. Both insufficient care and treatments that end up below the standard of care for similarly situated veterinarians serve as common bases for these client complaints. *L & E* book p. 117-118. This is covered in far more detail in the section on this subject matter that follows section I of these hand outs.
4. The failure to offer **timely referrals** - not at all or too late to be of value.
5. The failure to show **adequate compassion and/or assistance**. *L & E* book p. 119-120.
 - a. When clients suffer personal injuries while restraining or caring for their pets or via a zoonotic disease, as in the *Paw and Order* video.
 - b. A failure to say “I’m sorry.” Major changes have occurred in legal principles that now encourage doctors to apologize for unexpected and/or undesired outcomes. In order to encourage this important part of the healing process, many states now have laws addressing this issue.¹

¹ American Medical Association Advocacy Resource Center, 2008. At least thirty states have enacted an “I’m Sorry” law for health care providers, including **Arizona, Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota,**

- c. With too much background noise and/or chaos at the time of euthanasia. This is why most practices schedule elective euthanasias as the last appointments of the day.
- d. When providing options and procedures for disposal of the patients' bodies.
- e. Missing appropriate opportunities to exude compassion when patients die by using a compassion board.

The use of a "Four-Hearted" Compassion Board as illustrated here helps staff members avoid inadvertent and embarrassing comments after clients' animals have died.



- 6. Aggravating the potential for complaints. *L & E* book p. 120-123.
 - a. **Making a diagnosis too quickly**, such that it makes prior veterinarians appear "dumb," incompetent or negligent because they missed what otherwise appears to be a simple diagnosis. "Dr. Topflight, how could you make a diagnosis of a squamous cell tumor of the toenail in less than a minute when Dr. Dumbdittie couldn't make that diagnosis even with x-rays, a fungus culture and two months of repeated visits?"
 - b. The **dilemmas faced by emergency clinicians** who see multiple cases where they lack records to explain prior care or clear evidence of omissions and commissions.
 - c. The **miserics suffered by specialists** who 1) wish the cases they are examining had been referred rather than having the owners forced to find them on their own, 2) wondering why the case wasn't referred days or weeks ago while there was a chance for success or 3) trying to figure out how to address the apparent incompetence, gross negligence or negligence of the prior doctor(s).
 - d. **Veterinary school clinicians** filled with extremely knowledgeable specialists who see "zebra diseases" in their specialty on a regular basis, teach students about their specialty and, thus, make generalists who miss diagnoses look ignorant, incompetent or negligent.
 - e. **Egotistical veterinarians** who truly believe and utter comments such as "If I had just seen 'Fido' yesterday, we most likely could have saved him."
 - f. Filing small claims court actions to collect unpaid accounts lead to large numbers of client complaints. Of special concern here is a claim that has been filed when it is likely that the diagnostic efforts and treatment were below the standard of care for the profession.

Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, Wyoming, and the District of Columbia. Generally these laws protect health care providers who express sympathy to a patient for an unanticipated outcome from having such statement used against the physician in a subsequent lawsuit. One of the criticisms of the current litigation system is that it stymies a provider from expressing any sort of apology for an unanticipated outcome because of the fear of being sued. The purpose of an "I'm sorry" or "apology" law is to encourage open communication between patients and physicians without fear of reprisal. The type of expressions covered by the law and their level of protection, however, vary among the states.

7. Diminishing the potential for complaints. See materials in Ethical Relations with Clients handout.
 - a. “I might have handled this case differently but I have the **advantage of hindsight.**”
 - b. “Our policy is **not to comment** on a patient’s prior care until we have the **facts from all the parties**”
 - c. “Our job at this time is to render treatment - we’ll obtain more facts later.” **Law & Ethics p. 122**
8. Avenues for addressing grievances. *L & E* book p. 123-130.
 - a. Talk with clients on a regular basis! Do not pass this job on to non-DVM practice health care team members alone. Meet with clients in person when face-to-face contact can nip a complaint in the bud.
 - b. VMA ethics committees or peer review committees.
 - c. State boards of veterinary examiners and courts of law.

II. **THE LAW OF NEGLIGENCE AND PROFESSIONAL LIABILITY**

In the limited amount of time available to discuss the important aspects of professional liability, we will briefly describe the basic elements of a suit for negligence. Thereafter, this presentation will focus on the very basics of the law of negligence in outline form. For far more depth, students are encouraged to read Chapter 6 of the *L & E* book.

1. Intent of Seminar

1. Familiarize students with the elements required to prove allegations of negligence.
 2. Differentiate straight negligence (slips and falls around premises) cases from professional negligence (malpractice).
 3. Provide an understanding of the defenses available to client complaints and allegations of business negligence or malpractice.
 4. Promote an understanding of the principles that reduce client complaints and, thus, time spent dealing with unhappy clients.
 5. Provide information and sample record forms that reduce exposure to legal actions.
2. **Defining Risk Management** - recognizing and handling complaints by clients and/or employees in manners that prevent, or at least minimize, the potential for a lawsuit and legal liability for negligence, malpractice and breaches of contract.
 3. **Definitions Used By Attorneys Filing Suits for Damages and State Boards For Disciplinary Actions**

All veterinary medical state boards respond to complaints from consumers in their state alleging various claims. The legal justifications for action stem from descriptive words found within each state’s disciplinary laws or regulations. Since it is rare for the administrative codes to define each of these, it usually is essential to look elsewhere for definitions. A Missouri state board case² against a veterinarian and other resources provide verbiage for the various terms.

- a. **Incompetence** means an inability to perform in the profession³ or a general lack of the “disposition to use an otherwise sufficient professional ability.”⁴
- b. **Gross negligence** is a departure from the standard of care so egregious that it shows a conscious indifference to a professional duty.⁵

²*Missouri Vet’y Medical Board vs. Jonathan Wilson, DVM, Case No. 07-00-19 VM.*

³Missouri Revised Statutes, Chap 1, §1.020(8).

⁴*Johnson v. Missouri Bd. of Nursing Home Adm’rs*, 130 S.W.3d 619, 642 (Mo. App., W.D. 2004).

⁵*Tendai v. Missouri Bd. of Regis’n for the Healing Arts*, 161 S.W.3d 358,367, MO. 2005).

- c. **Misconduct** is the willful doing of a wrongful act.⁶
 - d. **Negligence** consists of doing something that a person of ordinary prudence **would not have done** under the same or similar circumstances or **failing to do** something that a person of ordinary prudence **would have done**. (*L & E* book p. 135-136)
 - e. **Repeated negligence** signifies no culpable (punishable or wrongful) mental state, **gross negligence** signifies conscious indifference and **misconduct** signifies bad intent. Those three terms are thus mutually exclusive. Courts infer the requisite mental state from the “circumstances of the particular case.”⁷
 - f. **Misrepresentation** is a falsehood or untruth made with the intent of deceit rather than an inadvertent or unwitting mistake.⁸
 - g. **Fraud** is an intentional perversion of truth to induce another to act in reliance upon it.⁹
 - h. **Dishonesty** is a lack of integrity, a disposition to defraud or deceive.¹⁰ Dishonesty also includes actions that reflect adversely on trustworthiness.¹¹
4. **The Burden of Proof (Weight of the Evidence) Rules**
- a. In criminal court cases, the burden of proof requires that the evidence prove the case beyond a reasonable doubt and with a unanimous vote of the jury.
 - b. With civil court negligence cases, the venue where lawsuits for compensation are brought, all that is required to fulfill the burden of proof is a preponderance of the evidence, i.e., greater than 50%. Additionally, depending on the jurisdiction, all that may be required in some cases is a simple majority vote of the jurors. In other cases, it requires a 75% vote of the jury.
 - c. In state board disciplinary actions, the burden of proof may vary by state. However, the initial research on the subject indicates that at least four states have case law establishing that they, as with civil court cases, they apply a preponderance of the evidence standard.¹²
5. **Presumptions.** As discussed in the video that Merial sponsored to help teach medical records and the law of professional negligence entitled *Paw and Order: The Profession on Trial*, the rules of evidence related to proving and defending lawsuits for negligence bring medical records to the forefront. Entries in business records that meet specific evidentiary requirements create a presumption that whatever **WAS** recorded in the record **WAS DONE**. Thus, when patient records are admitted in a trial or state board hearing to help defend one’s actions, the opposing party has the burden of **going forward with the production of evidence** to prove that what **WAS** entered **DID NOT OCCUR**. Since our veterinary patients cannot talk, that is a difficult legal battle for the opposition to win.

III. **THE FOUR ELEMENTS OF A CAUSE OF ACTION FOR NEGLIGENCE**

The first thing to understand about this area of the law is that there are two similar but different types of claims involving negligence: 1) basic or traditional negligence (most often involving slips, falls or injuries to clients or bystanders where the business is liable) and 2) malpractice or professional negligence where doctors are liable.

⁶*Grace v. Missouri Gaming Comm’n*, 51 S.W.3d 891, 900-01 (Mo. App., W.D. 2001).

⁷*State v. Jensen*, 184 S.W.3d 586, 589 (Mo. App., S.D. 2006).

⁸*Hernandez v. State Bd. of Regis’n for the Healing Arts*, 936 S.W.2d 894, 899 n.3 (Mo. App., W.D. 1997).

⁹*Id.* at 899 n.2.

¹⁰MERRIAM-WEBSTER’S COLLEGIATE DICTIONARY 359 (11th ed. 2004).

¹¹*See In re Duncan*, 844 S.W.2d 443, 444 (Mo. banc 1992).

¹²*See State of Connecticut, Connecticut Board of Veterinary Medicine*, Petition No. 970730-047-015; *Before the Minnesota Board of Veterinary Medicine In the Matter of Duane E. Wyatt, D.V.M.*, License No. 04976; *Before the State Board of Veterinary Medical Examiners of South Carolina In the Matter of Chelsey Kennedy, D.V.M.*, License No. 1518, (Case No. 2003-49); *State of Vermont Veterinary Board In re: John W. Paeplow, DVM*, License No. 052-000531, VE12-0504;

To win a civil court lawsuit for damages as a result of someone's alleged negligence, victims and their attorneys must prove the existence of each of four elements: 1) duty, 2) standards of care, 3) proximate cause and 4) damages. Each is described briefly below. For an in-depth discussion of the subject, see the chapter 6 in the *L & E* book p. 131-173.

State Board Actions Seeking Disciplinary Actions

Interestingly enough, when it comes to allegations of professional negligence brought by state boards of veterinary medicine, it usually is not essential to prove the existence of the 4th element, damages. In many cases, state boards also do not require proof of the 3rd element **proximate cause**. This is because state boards do not award damage recoveries to consumers who seek assistance with allegations of negligence. Instead, they are concerned primarily about whether licensees met the standards of care for the practice of veterinary medicine. When licensees are found to have provided care below these standards, the boards can 1) revoke, 2) suspend or 3) restrict their licenses, 4) place them on probation or 5) require that they complete various types of continuing education courses or 6) community service.

The Elements In Civil Court Actions for Damages

The remainder of this handout outlines key legal principles under each of the four elements of a cause of action (lawsuit) for negligence.

- A. **The “DUTY OF CARE.”** With respect to this first element, the requirement is to prove that a general duty of care existed to the party alleging the negligence. This includes a duty of care to prevent injuries to clients, bystanders, volunteers, any of the cases ambulatory clinicians attend off their premises or the animals that clients bring with them to their premises and even to invitees (people who stop in at a place of business merely to get directions to another location or use a restroom). In general, as with most establishments open for business to the public, trespassers are the only parties to which veterinary practice owners do not have a duty of care.
1. **The Duties In Traditional Negligence** cases have everything to do with how business owners and individual citizens manage the day-to-day way they conduct their lives. This includes a duty to foresee hazards and injuries that reasonable businesses and people should envision would prevent injuries to others. Among the duties of care here are the requirements to 1) maintain a safe parking lot, 2) drive one's ambulatory vehicle in a safe manner, 3) provide a reception room free of obstacles or substances that could result in slip and fall risks and 4) assure that all pets in the facility are restrained or confined in manners that would prevent injuries from occurring to other clients and/or their pets from the time they come through the front door until they leave the premises.
 2. **The Duty under Malpractice**, also called **Professional Negligence**, cases is integrally related to the provision of medical advice and care. The application of this legal principle can start long before a doctor at the practice undertakes the care of a patient.

The Issue of “When?” A good example, and one that occurs all too frequently, entails the provision of 1) incorrect advice from front office reception staff to clients calling about pregnant mares, livestock or pets that are in labor and struggling to give birth, 2) phone calls about male cats “yowling” with pain and squatting as if they are constipated (related, of course to lower urinary obstructions) and/or 3) large breed, deep chested dogs that have eaten recently and now are bloated and repeatedly vomiting up nothing but than ropy saliva (classic for gastric dilatation volvulus syndrome). Each of these constitutes an emergency situation that needs to be examined and attended in the very near future.

Erroneous advice from undertrained support staff or greenhorn doctors as to how soon an examination is required can lead to the death of a patient, terrible public relations problems and allegations of negligence, even if no lawsuit or state board complaint occurs. In the eyes of clients, perception is reality and it is for this reason that the law of professional liability poses serious risks for veterinary practices.

The application of the doctrine of professional negligence continues next with incompetent or negligent patient triage upon the arrival of the ambulatory doctor at the patient's location or at the facility where the medical care will be rendered. The clearest potential for the onset of the law of malpractice occurs after attending doctors provide estimates or medical care plans for their patients. It is usually at this point that clients utter express, oral consents such as "go ahead and proceed, Doctor." However, as discussed in contract law, acceptances can also be implied by the actions of the parties. Whatever the case, once a contract for the provision of veterinary care exists, the law of professional negligence now very clearly encompasses all medical decisions made and care rendered from this point forward, until patients are stable and released from care.

- a. This same **Duty** element extends to the growing duty, most notably in small animal practice, to inform clients about access to and outright referrals for overnight, week end, holiday and/or 24-hour emergency or critical care. *L & E* book p. 155.
 - b. As discussed and clarified later, this **Duty** also extends to the duty to offer referrals to specialists.
3. **The Duty of Care In State Board Cases.** An interesting twist occurs when actions for professional negligence are brought by state boards. In these cases, the end result is a disciplinary action against one's license, not a dollar award of damages caused by the negligence. In these cases, the duty is owed to any consumer of veterinary services in the state in which the defendant veterinarian is licensed and for which the licensed doctor held him or herself out as capable of caring for the species of animal that suffered from a deviation from the standard of care
 4. **The Legal Duty to Provide Emergency Care** is governed by each state's veterinary practice act. See the *L & E* book p. 134-135. The ethical duty to provide such care is founded in the *AVMA Principles of Veterinary Medical Ethics*. See also notes for moral-ethical-legal decision-making.
- B. **THE STANDARD OF CARE.** This subject breaks into two sections: standards for business owners and how they are expected to maintain their premises vs. standards for veterinarians who have been sued for malpractice (also known as professional negligence.) See the *L & E* book p. 135-136.

For veterinarians to be held liable for a failure to meet the standard of care in medical or surgical cases, proving or defending this second element of cause of action for negligence usually requires the most research and effort. It entails providing evidence that the diagnostic efforts and treatments rendered were equal to the care that would have been provided by reasonably skilled and careful veterinary colleagues faced with the same or similar circumstances. It is in this arena where the testimony of expert witnesses is critical.¹³

1. **Positions available for experts** to take include the
 - a. **Two schools of thought**" arguments consisting: of
 - i. **the majority viewpoint vs.**
 - ii. **the respected minority** position;
 - b. The **error in judgment** position;
 - c. Using written **consents to allow for unorthodox treatments** as a way of opting out of orthodox ones;

¹³ See *Law and Ethics of the Veterinary Profession*, Chapter 12, The Veterinarian as An Expert Witness.

- d. The “it’s ok to **use your experience and/or best judgment**” doctrine, regardless of whether it is the standard for the procedure or industry;
 - e. The “**there was no hope anyway,**” experimental protocol theory so anything goes;
 - f. The “**it was common knowledge**” by people position that precludes the need for testimony by experts because all people of average intelligence should have been aware of possible risks.
 - g. For details and further explanations regarding these points and more, please see chapter 6 in the *Law and Ethics* book.
2. **The Similar Locality Rule.** At one time this legal doctrine required that medical professionals need only be compared with the standards of care practiced in the community or locale where the defendant doctor practiced. Because of the volume of journals, continuing education programs, books, webinars and online courses, the similar locality rule is dead in most jurisdictions. Instead, a state or region wide standard of care generally is applied in professional negligence cases. *L & E* book p. 136.
3. **Omissions and Commissions.** **Commissions** are the ugliest precursors to claims of negligence and incompetence. The following list is being provided, correlating with my first hand experience as an expert witness and/or advisor.

The number in parenthesis reflects the number of times I have been privy to such commission cases: a) amputating the wrong leg (1), b) ligating and excising the ureters when performing an OVH on a female cat (6), c) attempting to hysterectomize a tomcat (2), d) euthanizing the wrong patient (2), e) ligating the pelvic urethra while castrating a male dog (1), f) dosage or drug administration errors that led to serious organ dysfunctions (2) g) using the wrong type of suture material and/or burying the wrong type in body cavities (3), h) faking or failing to euthanize a patient after the client had signed a consent for euthanasia (8). See also *L & E* book p. 136-7.

Of these two standard of care issues, **omissions** are the more common. They include omitting to do something that prudent veterinarians would have done under the same or similar circumstances. My experience here is that the following omissions are the most common. As previously, the number of cases in which I have observed them in cases wherein I was an expert witness are found in the parentheses at the end of each section. a) a failure to take at least two radiographic views of all body cavities and extremities, thus, missing an otherwise clear diagnosis (dozens), b) the failure to check urine specific gravity when evaluating tentative diagnoses of renal failure (dozens), b) the failure to obtain a minimum patient data base by failing to perform inexpensive fecal tests, hematocrits, Azo and Dextrostix tests, full urinalyses and total protein assessments, as quick diagnostic tests (dozens), d) omitting to discuss the value and/or need for referrals to all-night emergency clinics (3) or specialists (3), e) the absence of the use of anesthetic monitoring equipment, and f) failing to use appropriate pain management drugs post surgery (2).

4. **Standards** for requisite number of hours for **Continuing Education** are set by State Board regulations. The failure to attend reasonable amounts of CE and at least the mandatory biennial numbers of hours set by various states’ boards of veterinary examiners seriously impacts the credibility of veterinary defendants as they attempt to defend their practice of the profession. *L & E* book p. 137-138.
5. **Standards Regarding the Provision of Care by Specialists.**
- a. **Offering or actually referring cases to specialists.** With the vast increase in the number of board certified specialists in all areas of veterinary medicine, the standards required for referrals to specialists are rapidly changing.

As covered in much more depth in the *L & E* book, key factors here include how expert are the experts and what distance will clients need to travel to avail themselves of such expertise.

The following regulations became effective in Pennsylvania in 2009. Interestingly enough, they probably codify what is already the widely accepted general standard regarding case referrals to experts.

49 Pa Code § 31.21. Rules of Professional Conduct for Veterinarians.

Principle 1. Competency.

- (a) Veterinarians should strive continually to improve their veterinary knowledge and skill, making available to clients and their colleagues the benefit of their professional attainments. A veterinarian should provide opportunities for professional colleagues who request to observe the veterinarian's practice to develop or improve a professional colleague's veterinary medical skills.
- (b) Veterinarians should seek, through consultation, the assistance of other veterinarians or other licensed professionals when it appears that the quality of veterinary service may be enhanced through consultation.
- (c) A veterinarian shall recommend referral to a specialist or otherwise more qualified veterinarian in any case if the care and treatment of the animal is, in the veterinarian's sound judgment, beyond the veterinarian's capabilities or equipment. In that case, a veterinarian may accept or continue care and treatment of an animal after the veterinarian has done the following:

- (1) Suggested referral.
- (2) Explained the rationale for referral.
- (3) Explained the possible complications from the veterinarian's lack of expertise or equipment.
- (4) Obtained written consent from the client.

b. **Standards of care for specialists.** The critical factor to understand here is that because specialists have sought additional training and passed examinations certifying their competence with respect to their specialty, they are held to much higher standards than are generalists. This is an important factor to discuss with clients when they question why such specialty care is so expensive.

c. **Standards for Specialists vs. Generalists**

- i. When generalists undertake the provision of care for patients that ordinarily are handled by specialists, they usually will be held to the standard of care for the specialist. Section (c) (1-4) of the above PA state board regulations above had codified a possible exception to this rule.
- ii. See *L & E* book p. 139-140 for additional discussion.

6. **Statutory Standards of Care.** These are found in the rules and regulations established by many State Boards of Veterinary Examiners. *L & E* book p. 141. They generally are defined using the prefix "minimums" and come in several forms, including:

- a. Standards for the facilities in which veterinary care is provided,
- b. Standards for maintaining and storing medical records, and
- c. Standards covering prescription drugs dispensed by veterinary practices.

It should be noted that in situations alleging the failure to meet the minimum standards of care, state board disciplinary action can result even without any proof of professional negligence or the opinions of expert witnesses. Moreover, the failure to meet even the minimum standards set by state boards makes it extremely difficult to defend allegations that veterinarians were within the standard of care for the provision of professional services that are integrally tied to those minimums.

It is rare for state boards to draft standards of care for the “practice of veterinary medicine” itself. Thus, whenever civil court lawsuits or state board complaints allege the existence of inadequate patient histories, negligent diagnostic procedures, interpretations of results and/or therapies, supporting or contradicting opinions of expert witnesses are required to make or break a case.

7. **Standards Regarding Liability For Patient Restraint.** *L & E* book p. 142

- a. Risks of injury from animal restraint problems come in three primary forms - a) injuries to people, b) injuries to animals, and c) injuries to staff members.
- b. In view of today's litigious society, one must now question whether it is within the standard of care to allow clients to restrain their own animals.
- c. To minimize the risk of liability caused by and/or the escape of animals from the reception area, practices are urged to place placards with the following information in clear view of the front desk so staff members can point to it when needed to convince recalcitrant owners of the hospital's policy.

The placard would read,

*Clients Must Be Able To Restrain Animals Safely in Our Reception Area or, For
The Safety of Themselves, Their Pets & Others, We Cannot Provide Service.*

- d. Criteria to be considered when restraining animals:
 - i. The age, size, and stature of the client(s) assisting with restraint;
 - ii. The person's level of experience restraining the species of animal about to be examined;
 - iii. The person's health and physical condition;
 - iv. The veterinarian's familiarity with the temperament and controllability of the patient;
 - v. The adequacy of the facilities available for restraint;
 - vi. The availability or non-availability of a trained veterinary assistant (during daytime hours trained personnel usually are readily available - after hours veterinarians may be required to use their clients as assistants);
 - vii. Method used for muzzling, twitching patients - best noncollapsing muzzles on the market available from Jafco Muzzles, www.jafcomuzzles.com, Dublin, CA 800-742-0389;
 - viii. Quality & quantity of training provided for assistants;
 - ix. The length of time required to complete and difficulty associated with the diagnostic or treatment procedure about to be performed;
 - x. The amount of pain that might be produced by the examination;
 - xi. The presence and location of bystanders;
 - xii. Financial resources of the owner and
 - xiii. The medical status of the patient and its ability to endure chemical restraint.

The **Low Stress Handling, Restraint and Behavior Modification of Dogs and Cats** book by Sophia Yin, DVM, MS is a must-own for every veterinary practice that treats dogs and cats. Filled with sensational photos that illustrate every low stress restraint technique available for cats and dogs, it includes seven different methods for restraining cats with towels.

Comes with a DVD that further illustrates the multitude of techniques depicted in the photos. Available at AAHA Bookstore and/or www.nerdbook.com. It is a fantastic staff teaching and training resource.

8. **The Ever Changing Standard Of Care.**

- a. With respect to delivery of veterinary care to animals, standards change remarkably fast because of the information explosion and today's technological methods available to deliver it. These include journal publications, CE symposia, webinars, lunch & learns, webcasts, detail reps, imaging, cardiology and other teleconsulting, online courses, subject material taught in veterinary schools and routine intraprofessional communications and chat sessions on Veterinary Information Network (VIN).

9. **Standards Regarding the Duty to Inform Clients About Preventive Parasite Control.** The Merial *Paw and Order: The Profession on Trial* video. This teaching program, presented all over the U.S.A. starting in 2004, has had a huge impact on the standards expected of practitioners regarding the provision of information to clients as a means of preventing the transfer of zoonotic parasites to humans. Other resources include:

- a. Novartis Animal Health, Merial and Bayer all have programs to educate veterinarians and their staff about the incidence of human parasitic diseases acquired from pets. Merial has a CD-Rom and book titled *Protecting Pets, Protecting People*. Novartis has had national teleconferences for employees of veterinary practices and animal shelters covering this subject. Bayer has worked to draft client consent forms to help limit veterinary liability.
- b. The Center for Disease Control and the American Association of Veterinary Parasitologists has a brochure to educate veterinarians, www.cdc.gov/ncidod/dpd/parasites/ascaris/prevention.htm and the CDC and Merial have a brochure to educate clients about these risks available from Merial or at www.cdc.gov/Healthypets/Merial_CDCBroch_rsgWEB.pdf.
- c. The Companion Animal Parasite Council, www.capcvet.org.

10. **The 10th Standard - Applying the Legal Consent Doctrine.**

- a. Veterinarians must understand the tie-in between contract law, the legal consent doctrine, the battle between the use of the terms "informed consent" vs. "written or legal consent" and the hope that future statutory changes and court precedents will eradicate the *informed consent* doctrine in veterinary medicine. See p. 1-6 of *Legal Consents for Veterinary Practices, 4th Edition* for an explanation of this battleground.
- b. The KEY INGREDIENTS needed for an educated, written, legal consent include:
 - i. Information about the medical and surgical alternatives.
 - ii. Explanations describing the procedure(s) in language and using teaching aids sufficient for owners to understand what will occur.
 - iii. Explaining clearly what you expect to accomplish (the outcome you anticipate) with your surgical or medical course of treatment.
 - iv. Informing of the most common or serious complications. (Medicine is an inexact science - be realistic).
 - v. Discussing the type and extent of follow-up care.
 - vi. Apprising clients of estimated fees and making arrangements for payments.
 - vii. Using written consent forms whenever indicated by the degree of risk and/or difficulty or complications associated with the procedure.

11. **Standards with Respect to Informing Clients About Zoonotic Diseases.** The Merial sponsored video entitled *Paw and Order: The Profession on Trial* and subsequent discussion covers a great deal of ground including;
- a. What veterinarians are expected to tell their clients about zoonotic diseases and how they can prove that they fulfilled the duty to do so.
 - b. Who are the experts - veterinarians or physicians?
 - c. Concerns about the “big and obvious” zoonotic disease - rabies - have always been at the forefront. However, according to CDC estimates, there are over one thousand cases of human ocular larva migrans per year and usually no more than one or two human rabies cases in the U.S.A each year.
 - d. Concerns about low incidence but emerging increases the numbers of infectious diseases such as leptospirosis.
 - e. Concerns about children and immunocompromised adults.
 - f. Concerns about the transmission of parasitic diseases from pets to humans including:
 - i. *Toxocara canis* - cutaneous and ocular larval migrans.
 - ii. Hookworms - cutaneous and visceral larval migrans, enteritis in children.
 - iii. *Baylisascaris* transmission from raccoons (and dogs?) to humans causing severe encephalitis.
 - iv. Toxoplasmosis - pregnant women
 - v. Bartonellosis – all cat owners but especially the immunocompromised..
 - vi. Tapeworms - hydatidosis.
 - vii. Heartworm disease in immunocompromised people.
 - viii. Giardia.
 - g. Other outstanding resources for veterinarians and their health care team to use to learn about zoonotic diseases is available at www.vetmedteam.com/classes where parties can enroll in free course material provided at VetMedTeam by the Companion Animal Parasite Council and/or two excellent courses offered by Merial entitled Zoonotic Diseases 101 and 102.

12. **Standards For The Administration Of Compounded Drugs.**

- a. These exist and originate in the FDA Compliance Policy Guidelines Manual (CPGs) Sec. 608.400 *Compounding of Drugs for Use in Animals*. See Legal Use of Drugs handouts for the rules pertaining to compounded drugs. Of particular concern regarding this issue and worthy of repeating here are the following facts:
 - i. The provision of these fly-by-night drugs from compounders that often compete with FDA approved drugs removes the incentive for the large, ethical pharmaceutical firms to research, develop, seek FDA approval and market new drugs because their costs will exceed their return on investment; and
 - ii. Perhaps the worst outcome of the continued use and sale of compounded drugs in the face of pharmacological evidence of their ineffectiveness is that such action will be determined to **constitute a criminal activity, i.e., fraud**. If this is the finding, it could void one’s professional liability insurance coverage because that policy covers only professional negligence, not fraud!

13. **Emerging Standards Relating To Pain Management.** These are based principally on AAHA’s standards found at www.aahanet.org) and in much more detail in the Legal Use of Drugs handout. As discussed in that hand out, new Pennsylvania state board rules and regulations require that practitioners use appropriate pain management drugs.¹⁴

¹⁴ Pa Title 49, Professional and Vocational Standards, Part 1 Department of State, Chapter 31. §31.21 Rules of Professional Conduct for Veterinarians. Principle 7, Responsibility to clients and patients.

(f) Veterinarians shall serve as patient advocates especially regarding the alleviation of pain and suffering, consistent with the prevailing standards of veterinary medical practice. Veterinarians shall utilize analgesic drugs, dosages, treatment intervals

14. **Guidelines for Care vs. Protocols vs. Standards of Care.** With increasing frequency, “guidelines” for veterinary care are creeping into the profession. Many of these are referenced in the points listed under this section. Although they are being drafted as mere guidelines, without the intention of being interpreted as standards, it is likely in the future that they will be treated as standards of care when presented in cases brought against veterinarians for professional negligence.

To complicate matters further as a result of the choice of words, many practices, particularly those seeking AAHA accreditation, are developing “protocols” for their doctors to use when treating cases. These could be easily confused with guidelines and/or standards when presented in a court of law. Thus, practices are encouraged **NOT** to draft their own “Standards of Care” especially when they are meant to serve as guidelines and references for diagnostic and/or therapeutic approaches to provision of veterinary care.

One can argue that the differences here are nothing more than semantics. However, using the term “standards of care” has an especially troublesome legal risk or side effect that should be avoided. The biggest difficulty and highest risk occurs when individual practices create *standards of care* for their practices. This almost assures that if they fail to follow those *standards*, it is an admission of negligence.

All of these terms may well just be the precursors to published standards, as has transpired in the human health care arena. Examples include:

- a. Guidelines for parasite control and treatment created by the Companion Animal Parasite Council (www.capc.org)
- b. Guidelines for feline and canine vaccinations produced by the AVMA, AAHA, and AAEP.
- c. Guidelines for 1) dentistry, 2) diagnostic imaging, 3) pain management and 4) medical records created by the AAHA (and found on their website, www.aahanet.org).
- d. It is for this reason that uses of words such as *protocols* or *guidelines* should be used not *standards of care* when these are drafted.

15. **Information Published** in the 2003 AAHA/Hill’s Study on **Client Compliance**. Titled *The Path to High-Quality Care - Practical Tips for Improving Compliance*, this study and publication has been impacting the importance of providing reminders to veterinary clients.

- a. As a result of this publication and seminars explaining its impact, benchmarks now exist that show that a **failure to send timely reminders** for core vaccines, heartworm tests, dental prophylaxes, feline and canine therapeutic diets and senior screening tests, medication refills, and/or other routine services could, in the future, constitute the negligent practice of veterinary medicine.

- C. **PROXIMATE CAUSE.** A short description of this requirement is that there must be proof that the defendant’s negligence or malpractice in failing to meet the standard of care was a material element and substantial factor in bringing about the type of injury that occurred. Although this sounds relatively simple, it often is the most difficult one to prove.

In fact, it often is impossible to prove this element of a cause of action without a gross necropsy and histopathologic or toxicological evaluation of one or multiple tissue samples. *L & E* book p. 145.

Interestingly enough, state board practice acts and regulations often do not require proof that a licensee's conduct had to have proximately caused the injury that prompted the board complaint. All that must be shown is a failure to meet the prevailing standard of care. This makes state board disciplinary cases much easier to prove than their counterpart lawsuits for negligence that are brought in civil court proceedings. It is important to note here that according to a 1998 *AVMA PLIT Newsletter*, settlements are 2.8 times LESS expensive when necropsies have been performed. Why? Because they frequently are the critical element required to prove or disprove proximate cause.

1. **The Foreseeable Component.** The injury must have been one that was foreseeable to a reasonably prudent veterinarian faced with the same or similar circumstances.
2. **Direct Cause.** The component of the proximate cause element requires proof that a reasonably close causal connection exists between the conduct of the defendant veterinarian and the occurrence of the injury. Put another way, the defendant's conduct must have been a material element and substantial factor in bringing about the type of injury or result that occurred. This is often the most difficult element to prove in a cause of action for negligence.
3. **Differences In Civil Court Cases and State Board Ones.** An element not readily apparent to licensed veterinarians is the fact that most state board findings of professional negligence **DO NOT require proof of proximate cause.** The mere proof that a duty of care existed to the consumer whose animal was harmed and the licensee's actions fell below the standard of care for treatment are sufficient to bring about disciplinary action.
4. **Unexpected Deaths and Necropsies.** Whenever veterinarians experience the unexpected death of a patient, it is wise to offer a necropsy to clients and, if they decline, have them read and sign Consent A-18 in the *Legal Consents for Veterinary Practices 4th ed.* entitled "Declination of a Necropsy." Included in that consent is the following statement,

I acknowledge that without such a procedure, I will never know what transpired, which may make emotional closure for me difficult or impossible. It may also preclude the ability to develop sufficient evidence for me to pursue successful legal action against any alleged perpetrator of...[this consent goes on to list five important crimes or causes of action].

- D. **DAMAGES.** Damage awards for negligence consist of dollars needed to compensate the victim. These come in several forms. *L & E* book p. 145-154. As is the case with the proximate cause element, state board findings of professional negligence **DO NOT require proof of the damage element.** The mere proof that a duty of care existed to the consumer whose animal was harmed and the licensee's actions fell below the standard of care for treatment are sufficient to bring about disciplinary action.
1. **Nominal Damages.** Usually \$1, acknowledging proof of the first three elements for a successful cause of action for negligence but without showing proof that damages were significant.
 2. **Compensatory - Special Damages.**
 - a. Lost income while the animals are out of production;
 - b. Lost use of the animal (stud fees, etc.);
 - c. Expenses incurred attempting to prevent the death or permanent disability of the patient (for example, follow-up veterinary medical expenses);
 - d. Lost profits (from the sale of a crop of puppies or kittens, etc.);
 - e. The market value of the animal;
 - f. The "unique property" theory of damages - 2005 *Bluestone v. All-Care Animal Center*, Fountain Valley, CA, \$9,000 recouped veterinary fees + \$30,000 unique value;¹⁵

¹⁵ This involves arriving at a value for property that has an exceptional sentimental attachment, such as a unique, irreplaceable family heirloom. *L & E* book p. 147.

- g. Any other damages that the plaintiff's legal counsel can drum up - including costs of psychological or psychiatric care.
3. **Compensatory - General Damages.** Except in unusual situations, courts have been very reluctant to allow for recoveries using this assessment of damages. Tennessee is the only state that currently allows up to \$5,000 of general damages for pet loss and in that state, veterinarians are exempt from these damages. See **Animal Law** hand out for considerably more information on this subject.
 - a. **Emotional Distress** (pain and suffering), loss of companionship – may be available when humans are injured, available in rare instances for humans who have lost pets. However, in 2010, the Vermont Supreme Court denied the award of lost companionship for pet loss.
 - b. **Intentional Infliction of Emotional Distress (IEDD).**
 - i. Plaintiff must prove: Defendant intentionally committed an “extreme and outrageous” act that caused severe emotional distress for which punitive and emotional distress damages are available.
 - ii. Must shock the conscience of judge/jury.
 - iii. Hard to prove this when veterinarians are defendants unless their actions or those of their staff constituted animal cruelty or they engaged in willful and wanton misconduct.
 - c. **Negligent Infliction of Emotional Distress (NIED).**
 - i. Courts generally allow recoveries only when plaintiffs:
 - (a) suffer physical injuries to or impacts on their bodies,
 - (b) were in a zone of physical danger, and/or
 - (c) are people whose children, spouses or parents were injured or killed and the plaintiffs witnessed the incident.
 - ii. In these instances, courts usually deny damage awards for significant others, life partners, friends, neighbors and sometimes grandchildren. They often describe the emotional distress as “parasitic” to some other grounding claim or injury so long as the distress is authentic and not unmanageably widespread.
 4. **Punitive Damages.**
 - a. Requires proof of malice, intent, fraud, gross and wanton neglect for the property of another.
 - b. OUCH! Not covered by liability insurance.
 5. **Aggravating Claims for Negligence and Related Damages.** Note: attempting to collect on past due accounts receivable may prompt clients to file lawsuits for negligence. Thus, before any such action is taken, it is critical to review the medical records to establish that the practice of medicine was within the standard of care before turning accounts over to collection agencies or filing small claims court actions.
- E. **DEFENSES TO LEGAL ACTIONS.** Just because veterinarians have been found to have been negligent or to have “malpracticed” does not mean that they are automatically liable for damages. This is where outstanding legal counsel and good expert witnesses can help immensely. See *L & E* book p. 157-160. Among the reasons precluding total or leading to partial veterinary liability are the following:
1. Contributory negligence of the complaining party.
 2. Assumption of risk by the injured party.
 3. Comparative negligence – many jurisdictions compare the degree of negligence and contribution to the injury for both parties and then partition damages accordingly.
 4. Failure to prove all of the above elements for a cause of action for negligence.
 5. Statutes of limitations, i.e., time periods within which lawsuits must be filed or plaintiffs lose the right to pursue them because of the staleness of the evidence.

F. **CLIMBING THE LADDER TO A PERFECT DEFENSE**

One of first questions from veterinary practice owners and their associates or practice managers that arises on a regular basis is “How can we create a perfect defense to a lawsuit for negligence?” The answer is buried in the following set of procedures. All members of the practice health care team must be made aware of the fact that there is no *practical* course of action that will prevent all lawsuits by clients or allegations of negligence brought by state boards. Instead, owners, managers, doctors and staff are admonished to climb the ladder toward this lofty goal.

1. Assure that time exists for a thorough **oral discussion** of risks, benefits and costs.
2. Develop or purchase and use **hand outs** that effectively educate clients.
3. Develop and use **systems to document the delivery** of such information in the hard copy or electronic files storing all medical record information. This is easily accomplished with the best practice management software systems on the market via the use of codes that can be checked to substantiate the provision of such information.
4. Understand that educational efforts via **client newsletters and/or target mailings** sent to clients regarding important animal health issues help build good defenses.
5. Train doctors and staff members to **enter notes about discussions** that took place **in patient records** as well as the author’s initials.
6. When risks are high or it appears **clients** are not listening intently, have them place their **initials in the medical records** indicating that they heard the discussion.
7. Develop **operations manuals** to educate staff members and develop a record system that **documents staff training efforts**.
8. As risks rise and clients need to provide educated consents as to various procedures, **use formal written consent forms** that are signed by clients.
9. Impractical, costly and not in general use, but a potentially effective step toward a perfect defense, would be cameras placed in exam room settings to produce **videotapes of risk/benefit/costs discussions and then archive** them.
10. The only perfect defense is one that is a joke. This entails placing a **judge and jury behind one-way mirror** overlooking the examination setting so that all parties can hear and observe the discussion taking place in an exam room or ambulatory setting. After the doctors discuss the risks, benefits and costs of care, they turn around and ask the judge and jury whether they believe their clients understood everything. When they all nod their heads with approval, one has finally arrived at a perfect defense.

IV. **PREVENTING COMPLAINTS** - the use of consent forms.

The publication entitled *Legal Consents for Veterinary Practices, 4th Ed* with all forms in English and Spanish is available from Priority Press, Ltd. Information about this 2006 publication is available at www.pvmc.net/publications. It contains 72 different consent and release forms and comes with a CD ROM containing Word versions of all forms for customization by individual practices. To maximize benefits, such forms have to be used wisely, as articulated on pages 11-19. Two examples are provided on the pages that follow.

V. **WHAT TO DO WHEN FACING CLIENT COMPLAINTS AND/OR PROFESSIONAL NEGLIGENCE LITIGATION**

The hand out for this material is contained in a separate document and is filled with a practical, cookbook type approach to the subject.

CONSENT FOR TREATMENT AND/OR ADMISSION

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(HOSPITAL OR CLINIC NAME)

Pet's Name _____ Approximate Age _____ Color _____ Breed _____

I, the undersigned **owner, owner's agent or Good Samaritan responsible** for seeking veterinary care for the pet identified above, certify that **I am/I am not** (circle one) **over eighteen years of age**, and hereby consent to the examination of this pet by staff veterinarians at (XYZ Veterinary Hospital). I also agree that after consultation with me, the hospital's doctors may prescribe medication for, treat, hospitalize, sedate, anesthetize and/or perform surgery on this animal. I understand that **some risks always exist with anesthesia and/or surgery and that I am encouraged to discuss any concerns I have about those risks** with the attending veterinarian before the procedure is initiated. Should some unexpected life-saving emergency care be required and the attending veterinarian is unable to reach me, the hospital's staff has my permission to provide such treatment and I agree to pay for such care.

I understand that an estimate of the costs for veterinary services will be provided to me and that I am encouraged to discuss all fees attendant to such care before services are rendered and during this pet's ongoing medical treatment. If this animal is hospitalized, I agree to pay a deposit of _____% of the estimated fees and assume financial responsibility for the balance of all services rendered on a cash, credit card or check basis at the time the pet is discharged from the hospital. In the event the pet is hospitalized for more than 48 hours and the attending doctor is unable to reach me, I understand it is my responsibility to call the hospital at least every 48 hours to inquire as to the medical status of this animal and the fees incurred for medical services up to that day. In the event of an open balance, I agree to pay a monthly billing and financing fee equal to 1.5% of the unpaid balance.

I understand that veterinary care during **nighttime hours and/or week ends** is provided at the discretion of the attending veterinarian. Continuous presence of personnel may not be provided during these hours.

I agree that either I, or an authorized agent of mine, will pick up this pet and pay for all accrued charges within 5 days after receiving written or oral notification that this animal is ready to be released from the hospital. Such notice will be given at the address maintained on the hospital's patient/client record or the address listed in my record. I agree that if I fail to comply with this policy, the XYZ Veterinary Hospital may handle this abandonment in the best interests of the animal and the hospital.

HAVE YOU TALKED WITH YOUR DOCTOR ABOUT THE FOLLOWING

1. The medical and/or surgical treatment alternatives for your pet?
2. Sufficient details of the procedures for you to understand what will be performed?
3. How fully your pet might respond or recover and how long it could take?
4. The most common complications and how serious they might be?
5. The length and type of follow-up restraint and care required?
6. How much this treatment is expected to cost and how payments will be handled?

Signature of owner or agent

Date

Signature of Parent/Legal Guardian
if owner/agent less than 18 yrs. old

Date

CONSENT TO DONATE PET REMAINS

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(practice name) is committed to improving the health and welfare of animals. By donating your pet's remains for use by the doctors of this hospital, you can become an integral part of this process. An educational memorial can help save other animals and improve the quality of their lives by providing our doctors and technicians with a source of knowledge in important subjects such as surgical anatomy and surgical techniques. After your pet's euthanasia or death, if you would like to donate your pet's remains to the (practice name) to be used for educational purposes, please sign the statement below.

As owner or duly authorized agent for the owner of the animal (pet's name) described below, I hereby release possession of my pet's remains to (practice name) for use in teaching and learning as the doctors deem appropriate.

SPECIES _____ BREED _____ SEX _____ COLOR _____

AGE _____ NAME _____

SIGNATURE OF OWNER/AGENT _____

OWNER/AGENT NAME (PLEASE PRINT) _____ DATE _____